

Developing Provider Networks for Medicaid Managed Long-Term Services and Supports Programs: Considerations for States

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State Medicaid programs are moving away from traditional fee-for-service delivery systems and toward capitated programs for long-term services and supports (LTSS) with the goal of improving health care quality and reducing costs. In order for emerging managed long-term services and supports (MLTSS) programs to best serve Medicaid's most vulnerable populations, states will need to ensure that health plans establish LTSS provider networks that address beneficiaries' diverse needs.

Although ensuring sufficient provider capacity is important for the move to MLTSS and integrated Medicare-Medicaid programs, there has been little guidance available to states or health plans on this topic. This technical assistance brief, supported by The SCAN Foundation, provides considerations for provider network development, reviews recent guidance, and offers examples of state practices for establishing MLTSS network adequacy standards.

Approach to MLTSS Network Development

MLTSS provider network development requires a different approach from traditional networks focused on primary and acute care. Most health plans are experienced in developing networks for relatively healthy populations in which care is episodic in nature. However, even many well-established health plans have limited experience in providing therapeutic, supportive, and ongoing services to older adults and individuals with disabilities.

Depending on the MLTSS services offered, health plans will need to contract with a broad range of providers for beneficiaries with complex needs (Exhibit 1). The majority of these providers are non-traditional in that they do not provide medical services. It is not unusual for people with multiple health conditions such as diabetes and heart failure to also experience depression, diminished cognitive function, and reduced functional abilities. These individuals may need personal assistance for bathing and hygiene, homemaker services, respite care, transportation to the pharmacy or medical

IN BRIEF

States establishing Medicaid managed long-term services and supports (MLTSS) programs need to ensure that health plans' provider networks address the diverse needs of Medicaid's most vulnerable populations. This technical assistance brief provides considerations for provider network development, reviews recent federal guidance, and offers examples of state practices for establishing MLTSS network adequacy standards.

appointments, meal preparation, or other services to remain in their homes and connected to the community.

Considerations for Creating MLTSS Provider Networks

As states begin the health plan procurement process for their MLTSS programs, they need to consider ways to ensure the adequacy of provider networks.² In its May 2013 *Guidance to States Using 1115 Demonstrations or 1915 (b) Waivers for Managed Long Term Services and Supports Programs*, the Centers for Medicare & Medicaid Services (CMS) identifies the

Exhibit 1: Types of Long-Term Services and Supports

- Nursing home or specialty care nursing home services
- Personal assistance services¹
- Homemaker/chore or meal preparation services
- Family supports
- Social adult day care and respite care
- Transportation
- Habilitation
- Supported employment
- Fiscal intermediaries for consumer-directed services
- Residential services (e.g., supported and shared living, adult foster care)
- Home and vehicular modification
- Other (e.g., care coordination, community transition, personal emergency response system)

key ingredients for innovative MLTSS program designs that support people in the community. Specifically, the guidance requires enhanced provision of home and community based services (HCBS) to ensure that MLTSS is delivered in the most integrated setting possible offering individuals opportunities for active community living and workforce participation.³ To do so, states must ensure that health plan networks include the right mix of providers and services to respond to individuals' needs in the community.

Available guidance and best practices from states suggest three factors that should be considered in MLTSS network development: (1) network adequacy; (2) provider qualifications; and (3) provider training. Taken together, these factors are critical in helping states transition from fee-for-service to MLTSS.

Network Adequacy

Network adequacy for LTSS differs from traditional network adequacy requirements for medical service delivery. State oversight includes ensuring that health plans develop and maintain a network that provides "adequate access" to services in the health plan contract.⁷ In particular, health plans must include sufficient types and numbers of LTSS providers in their networks to meet historical need and must be able to add providers to meet increased beneficiary needs in specific geographic areas. Network adequacy can be assessed along a number of dimensions including:

- Number of providers;
- Mix of providers;
- Staffing levels;
- Hours of operation;
- Accommodations for individuals with physical disabilities (e.g., wheelchair access) and barriers to

communication (e.g., translation services, hearing impairments); and

- Geographic proximity to beneficiaries (to allow the provider to get to beneficiaries, or beneficiaries to get to the provider, depending upon the service).

Health plans must maintain networks that can expand and contract to meet members' service needs. Information systems can help plans to track service use and population-level patterns in the needs of their membership. For example, if a plan sees an increasing number of members with dementia or mobility limitations, it may want to contract with more social adult day care centers or home modification contractors.

Provider Qualifications

LTSS providers such as nurses and home health aides require specific licensure and professional credentials, while providers of transportation, respite, meals, and other supports may not. In these cases, health plans will need to rely on other methods such as past performance assessments or references to determine the provider's ability to deliver services to beneficiaries.

CMS' recent guidance advises states to adopt standard qualifications, credentialing, and training requirements for non-licensed or non-certified MLTSS providers for use by health plans. Further, plans must adhere to applicable requirements for criminal background, abuse registry, or other required clearance checks.⁸ States such as New York have already used criminal background checks as a tool to verify and attest to the qualifications of paraprofessionals working in the home. Arizona does not require the use of criminal background checks, but instead permits health plans to

Ensuring Network Adequacy: Two Approaches

New Jersey: Using Any Willing Provider Status. On January 1, 2014, under their approved 1115 Comprehensive Waiver, New Jersey will move the HCBS under their fee-for-service long-term care program to MLTSS. On July 1, 2014 individuals receiving care in nursing facilities or specialty care nursing facilities will enroll in MLTSS. To ensure that beneficiaries have uninterrupted access to care, health plans will apply an "any willing provider" status for nursing facility providers for two years. This means that a beneficiary may receive services from any nursing facility provider that satisfies credentialing requirements and accepts the state-set reimbursement rate from the health plan.⁴ Use of any willing provider increases continuity of care and preserves existing beneficiary/provider relationships. It also allows the pool of providers to expand and contract as needed to serve the population.⁵

Arizona: Allowing Flexible Reimbursement Rates. Health plans participating in the Arizona Long Term Care System (ALTCSS) – Arizona's MLTSS program – are paid a capitated rate by the state. However, with the exception of a set base rate for skilled nursing facilities, the state does not dictate the reimbursement rate for any other MLTSS service. Subcontracts to provide services such as respite care or home modification are negotiated between the provider and the health plan. This arrangement gives health plans the flexibility to shape their networks and direct their reimbursement to the services that best meet clients' needs. This also gives plans the flexibility to respond quickly to a sudden increase in members or increase in demand for a particular type of service.⁶

set provider qualifications for their networks. It also requires competency assessment for in-home direct care workers. Workers must score at least 80 percent on a written exam and pass a hands-on practical exam to be deemed qualified. Both must be completed within 90 days of employment.⁹

Provider Training

Most MLTSS providers will be new to managed care. Health plans will need to train these providers to help them achieve program goals such as promoting health and wellness, providing coordinated care, improving beneficiary experience of care, and promoting efficient use of services (Exhibit 2). These providers also need to understand managed care processes for credentialing, requesting a prior authorization, submitting a clean claim electronically or by mail, verifying member eligibility for Medicaid and health plan enrollment, and submitting an appeal. Additionally, because MLTSS providers have more intimate relationships with beneficiaries – establishing relationships with family and caregivers and working in their homes – health plans need to train MLTSS providers to watch for signs of elder abuse/neglect and financial abuse.

Training MLTSS providers is time consuming, so plans will need to allow adequate time for training before program launch. MLTSS providers may be smaller, located in more rural areas, or work outside of their offices more than primary and acute care providers, making the scheduling of training more difficult. Training may also need to be provided across wide geographic areas. Many providers may need hands-on and even in-office billing training. Trainings can be offered in several ways including face-to face, webinar, or online self-study.

Exhibit 2: Topics for MLTSS Provider Training

- Appeal submission
- Care coordination
- Claims submission and payment
- Conflict resolution
- Coordination of benefits
- Credentialing
- Cultural competency
- Disability literacy
- Eligibility verification
- Enrollee rights
- Health plan operations and billing systems
- Health plan policies and procedures
- Prior authorization requests
- Provider communications
- Quality improvement

Additional training may be required after program launch as providers gain familiarity with health plan operations and procedures, such as new requirements for electronic billing. In Minnesota, the health plans developed a shared simplified billing portal for small providers who were not set up for electronic billing.

Suggested MLTSS Provider Network Access Standards

Several states, such as Arizona, Minnesota, New York, and Tennessee, have well-established Medicaid MLTSS programs. Their experiences help inform the development of LTSS network adequacy standards. Following are strategies states may consider:

1. Use Acute Care Standards Where Appropriate

Health plans can continue to use traditional provider network standards for acute care providers such as geographic distance and number of providers. While not ideal for community-based services like home delivered meals or home modifications, time and distance standards may still be appropriate for services offered in a “bricks and mortar” settings such as skilled nursing facilities or adult day centers.

2. Require the Use of Objective Measures

Some health plans have started using in-office wait time standards to access network adequacy. States may also require health plans to track and report the interval between service request and service delivery.

3. Formalize the Role of Caregivers

Requiring training or formalizing caregivers/ peers to act as care coaches is another way to relieve a shortage of LTSS skilled staff. Care coaches are often used in behavioral health settings to assist individuals who are working through addiction issues. States may want to implement a training or caregiver certification program to formalize the role of current voluntary, informal caregivers.

4. Use Alternative Service Delivery Models

One way to bolster provider networks could be to use alternative service delivery models such as electronic communication, telemedicine, or team-based care/roving care teams. These alternative service delivery models could meet the needs of MLTSS populations in rural areas. Several states, including New York and Minnesota, either use or plan to use remote monitoring or telehealth services to meet service needs in rural areas of their states.

5. Use Out-of-Network Providers/“Any Willing Provider”

Use of out-of-network providers may be one way of providing LTSS services that may only be needed on a time-limited or infrequent basis (such as home modifications). Additionally, some states such as New Jersey and Tennessee have elected to use any willing provider to ensure continuity of care while transitioning from fee-for-service to MLTSS.

6. Use Standards Reflecting MLTSS Provider Functions

States and health plans may require references and proof of licensure in lieu of the formal credentialing process that other providers such as physicians must go through. Additionally, states may consider other attributes and qualifications such as timeliness and going through specific trainings for a primarily paraprofessional workforce that works directly with individuals in their homes and establishes long-term relationships with beneficiaries and their families.

7. Require Plans to Conduct Annual Assessments of Member Needs

States could require health plans to conduct an annual (or more frequent) member assessment to determine if provider networks are able to support members' needs. Aggregate data from the assessment will help to identify gaps in network coverage, and plans would propose corrective action plans to eliminate these gaps. States could propose financial penalties or limit plan enrollment until adequacy issues are addressed.

Both Arizona and Minnesota use such analyses to identify gaps in their networks. In Arizona, plans are required to complete a gap analysis on a monthly basis, documenting all gaps in service for members who receive attendant care, personal care, homemaker services, and respite care. The analysis provides an explanation of gaps in service and defines the steps that are being taken to fill them, including network enhancements. Minnesota chooses to complete the gap analysis at the state level and then work with the plans to narrow any identifiable gaps in the network.

Conclusion

Network access standards for LTSS providers need to reflect the differences from traditional medical delivery systems in terms of time, scope, duration and location of service provision. The experience of a few states with MLTSS programs is helping to identify emerging best practices to better tailor network requirements to the differing nature of LTSS. As MLTSS programs evolve, it will be important to monitor network access based on objective criteria. Increased sophistication around LTSS quality measurement will help states and health plans to develop standards that not only measure access but also the quality of network providers.

New Jersey: Putting it All Together

After receiving extensive stakeholder input, New Jersey continues to refine contract language to reflect current national best practices around MLTSS provider network adequacy. As of July 2013, the draft health plan contract provisions address provider network adequacy after the MLTSS “any will provider” period ends. The following draft language requires contractors to:

“...contract with a sufficient number of NFs, SCNS, ALFs, and CRSs in order to have adequate capacity to meet the needs of MLTSS members. Specifically to HCBS services, NJ will require plans to have adequate HCBS provider capacity to meet the needs of each MLTSS member receiving HCBS services.

At a minimum, the Contractor shall contract with at least two (2) providers for each HCBS, other than community-based residential alternatives, to cover each county. For HCBS provided in a member’s place of residence, the provider does not need to be located in the county of the member’s residence but must be willing and able to serve residents of that county.

The state will further require plans to submit reports that address provider network, service initiation, missed visits, service utilization and continuity of care and will use the data provided in these reports to further establish MLTSS provider capacity requirements and develop performance standards, benchmarks and associated liquidated damages for non-compliance.”

New Jersey plans to incorporate more detailed criteria that reflect LTSS provider landscape in the future.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

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Endnotes

¹ Some states include personal assistance services under their Medicaid State Plans while others include this as a service, or supplement to a limited State Plan service, through home- and community-based services waiver programs.

² Centers for Medicare & Medicaid Services. "Managed Long Term Services and Supports: Provider Networks." Available at: <http://www.medicare.gov/mltss/design/design17.html>.

³ Home- and community-based services are defined as those services that are "made available to support individuals living at home or in a community-based setting; these may include home health care, durable medical equipment, assistive technology, chore services, nursing care, transportation, adult day care, in-home meals, and more." Centers for Medicare & Medicaid Services. "Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs." May 2013. Available at:

<http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf>.

⁴ This does not preclude nursing facilities from pursuing a different rate of reimbursement if they seek an exclusive arrangement with the health plan for a specified service area.

⁵ Information obtained from Joe Bongiovanni, Director, MLTSS and Contract Logistics, Office of Managed Health Care, Division of Medical Assistance and Health Services, NJ Department of Human Services.

⁶ June 4, 2013 Interview with Jami Snyder, Operations Administrator - Acute and Long Term Care Division of Health Care Management, State of Arizona.

⁷ Ibid.

⁸ Centers for Medicare & Medicaid Services, 2013, op. cit.

⁹ Jami Snyder, op. cit.